ASSESSMENT OF THE RESPONSIBLE PARENTHOOD PROGRAMS OF THE PERUVIAN CHRISTIAN FAMILY MOVEMENT AND ASSOCIATION OF LAYWORK FOR THE FAMILY

527-0160

A Report Prepared By
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During The Period
SEPTEMBER 10 THROUGH SEPTEMBER 22, 1973

Under The Auspices Of
AMERICAN PUBLIC HEALTH ASSOCIATION

In Agreement With The
U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

AUTHORIZATION:
AID/csd 2604-TO1
Ltr.POP/FPS:8/15/73
APHA Assgn. No. 101

FORWORD

In response to a request through the Agency for International Development (AID) the American Public Health Association provided two consultants to carry out an evaluation of "the administration and delivery of services" of the programs of two Peruvian organizations: The Christian Family Movement (MFC) and the Association of Lay Work for the Family (ATLF).

Before proceeding to Peru, the consultants met with staff members of AID and the representative of the Family Planning International Assistance (FPIA) who serves as the project officer for the MFC and ATLF Programs. Both Peruvian programs are administered and supervised by the international division of Planned Parenthood - World Population, (FPIA). It was during this briefing session that the consultants learned that their principal mission was to gather and analyze data which would assist donors in making a decision about continuing support for the programs.

The AID grants for the fiscal year (FY) 1973 were the first to be channeled through FPIA and covered the period July, 1972 through June, 1973. When the grants for FY 74 were made by FPIA they covered only the first six months and were set at the FY 73 level of funding rather than what had been proposed by the two organizations. It was stipulated by AID that an evaluation was to be carried out during this six month period and FPIA was notified that when the results of the evaluation were available, a decision would be made regarding the budget requests which had been submitted for one year funding. The amounts approved for the first six months of FY 74 were $34,528 for MFC and $48,405 for ATLF.

The consultants worked in Lima from September 11 through 21, 1973. As can be seen from the itinerary, included as part of this report, two and one half days were used to consult with staff members of the Church World Service, Peruvian Association for Family Protection, AID/P Mission, and the Ford Foundation. The remaining six and one half days were spent as follows: three days with MFC and three and one half days with ATLF. An additional half day with MFC, scheduled for Saturday September 15, was canceled due to the illness of the staff member with whom the consultants expected to meet. The consultants also visited 12 of the 43 clinics to observe educational and medical activities and to discuss problems and suggestions for improved operations with clinic staff and outreach workers. The consultants also attended three evening meetings to observe sessions of responsible parenthood courses.

Obviously, the time available for the assessment of the two programs was inadequate for an in-depth study of operations. Much of the data requested by the consultants was not readily available and while the staff of both organizations made every effort to assemble the needed information, some of it was not ready until the last day of the consultation period. This did not permit a careful perusal of the data to determine its completeness, and for this reason the data obtained from MFC is more complete in some respects and that from ATLF is more complete in others.

The project officer of FPIA arrived in Lima during the last week of the consultant visit. His stated purpose was to assist MFC and ATLF prepare new budget submissions covering the ten month period October 1973 through June 1974. This surprised the consultants inasmuch as they had anticipated that new budgets would be prepared after the assessment was completed.

In a sense the visit of the project officer was fortunate in that he provided answers to some of the questions which had been puzzling the consultants and for which answers could not be obtained in Peru. The consultants had not been able to ascertain why the equipment and supplies which were to be provided by FPIA in FY 73 had not been received by either MFC or ATLF. Officials of both organizations stated that they had been assured that orders had been placed, but at the time of the consultant's visit no word had been received as to when the specula, projectors and other needed items might arrive. The FPIA project officer explained that while the orders had been placed with the U.S. Government Services Administration (GSA), as far as he could determine the items had not yet been purchased, much less shipped to Peru. He stated that a new U.S. Government ruling in November, 1972 made it mandatory for GSA to serve as the purchaser of most equipment and supply items for AID funded projects. He mentioned that since FPIA is a relatively new organization it has no stockpile of commodities on which to draw and, therefore, must await action by GSA. He also stated that since the FPIA requirements are relatively modest, in comparison with other organizations, their requests for GSA purchases seem to have a low priority.

AID/W debriefing of the team was delayed until October 26, because of the illness of one of the consultants. In the meantime a cable from Peru provided sufficient information from the team AID/P departure interview for AID to make a decision to fund the projects for an additional 12 months based upon the budget requirement submitted by the FPIA project officer after his September visit to Peru. The newly approved budgets cover a one year period from

October 1, 1973 through September, 1974. While the new grants will not permit some of the changes believed important, they do guarantee continued operations for an additional 12 month period. Hopefully, during the next few months the technical assistance which the consultants believe necessary for both MFC and ATLF will be provided and their FY budget submissions will reflect more effective program operations.

The report which follows is divided into three sections. The first, entitled "Principal Conclusions and Recommendations", is intended for the exclusive use of AID and FPIA; the second section is intended for use of MFC and the third for ATLF. Both Peruvian organizations requested copies of the assessment of their program and it is hoped that AID will see fit to provide them with the appropriate sections of the report. The consultants recommend that Section II be reproduced and sent to MFC and Section III to ATLF. It is not recommended that the assessment of ATLF be sent to MFC. Both organizations have strengths and weaknesses but, in the interest of developing sound programs, little will be gained and much could be lost by providing them with information which could undermine the cooperative spirit which the consultants attempted to foster. Unfortunately, the leadership of ATLF has been led to believe that their program is superior to that of MFC. More unfortunate yet is that MFC staff has been led to believe that their operation does not measure up to that of ATLF. The consensus of the consultants is that both programs have room for improvement, but that MFC is handicapped to a greater extent than ATLF because of a smaller staff and budget; in spite of the fact that there is no significant difference in the scope of operations or in the results achieved.

Throughout the report the responsible parenthood program of MFC will be identified by the use of those initials although the actual name of the program is the Program for Promotion of the Marriage and Family. The program of ATLF is commonly referred to as PALF (Program of Family Lay Apostolate), therefore, thoughout the remainder of the report the latter initials will be used to identify this program.

A. Itinerary of Consultants

September 10, 1973	a.m. -	Briefing at AID/Washington attended by AID officials and the project officers of FPIA and APHA.
	p.m. -	Travel to Lima, Peru.
September 11, 1973	-	Orientation with AID/Lima. Tentative schedule developed and appointments made.
September 12, 1973	a.m. -	Orientation with MFC headquarters staff.
	p.m. -	Orientation session with PALF headquarters staff and visit to PALF sponsored clinic at Hogar del Madre.
September 13, 1973	a.m. -	Meeting with family educators of MFC to discuss educational component of program.
	p.m. -	Visits to MFC sponsored clinics in El Agustino and Villa El Salvador.
September 14, 1973	a.m. -	Visits to MFC sponsored clincis in Zarumila, Dos de Mayo, San Martin de Porras and Comas Pisto.
	p.m. -	Attended Responsible Parenthood course conducted by leader couple of MFC
September 17, 1973	a.m. -	Visits to Peruvian Association for Family Protection (APPF), the Church World Service and Ford Foundation.
September 18, 1973	a.m. -	Meeting with headquarters staff of PALF to discuss organization, problems, and methods of operation.
	p.m. -	Visits to PALF sponsored clinics in Bonilla, La Perla and Cuidadela Chalaca.

September 19, 1973	a.m. -	Dr. Deju met with medical director of PALF to discuss medical assistance program. Miss Kraft met with the chief of courses, the supervisor of leader couples, and the chief of social service to discuss the educational program.
	p.m. -	Visits to PALF sponsored clinics in Reynoso and Callao Health Center. Attended night session in Bonilla conducted by the chief of PALF courses and another in Villegas conducted by a leader couple.
September 20, 1973	a.m. -	Meeting at PALF with chiefs of departments for discussion of problems and to verify program data obtained.
	p.m. -	Wrap up session at MFC with director, administrator and family educators to discuss findings and recommendations.
September 21, 1973	a.m. -	Meetings with AID staff and AID/Lima Mission Director to discuss findings and recommendations.
	p.m. -	Wrap up session with members of the Directing Committee of PALF to review findings and to discuss recommendations.
September 22, 1973		Travel to U.S.A.

B. Individuals Contacted

1. <u>MFC</u>
   Ricardo Subiria, M.D.
   Irma Subiria
   Godofredo Livia, M.D.
   Oscar Castillo
   Ricardo Ballena, M.D.
   Luis Retamozo, M.D.
   Raul Rojas, M.D.

Luis Rondon, M.D.
P. Urbano Sanchez
Betty Adams Figueroa
Olga Becerra de la Cruz
Nelly Melgarejo de Bedoya
Tania Ruiz Gonzalez
Teresa Ganaha Miyasato

2. PALF
Heli Cancino, M.D.
Guillermo Tagliabue M.D.
Carlos Flores-Guerra F.
Enrique Bartra Serra
Walter Angulo, M.D.
Socorro Castro, M.D.
Jose Pineda, M.D.
Sergio Yong, M.D.
Nelly Galliani
Yolanda Chirinos
Blanca Godoy
Guillian Guillen
Martha de Laudi
Norma Odicio
Marcial Bartra Serra
Armando Rojas

3. Other Organizations

a) U.S. AID Mission

Donald R. Finberg
Charles Briggs
Gloria Nichtowitz

b) Peruvian Association for the Protection of the Family

Carlos Alfaro, M.D.
Carmen de Thuys

c) Church World Service

Rev. Lawson Lee

d) Ford Foundation

James Trowbridge

PRINCIPAL FINDINGS AND RECOMMENDATIONS

Findings

The investment being made by donor agencies for the responsible parenthood programs of MFC and PALF is justified and it is recommended that it be continued until support is forthcoming from other donors, local or international, or until the government of Peru underwrites and finances family planning services as a normal part of its publically supported health care system.

In Peru the Church and government attitudes toward family planning are softening. There is a growing recognition among some of the clergy that in the absence of family planning services the achievement of a goal of responsible parenthood is difficult if not impossible. Also, increasing numbers of health leaders are beginning to appreciate more fully the fact that child spacing is a desirable health measure; that alternatives to abortion and excessive numbers of pregnancy are essential to the achievement of improved maternal and child health; and, therefore, that family planning counselling and services should be available to those who depend upon publically supported health services.

The responsible parenthood programs of MFC and PALF have had, and are continuing to play, a vital and significant role in bringing about these changing attitudes. The Catholic hierarchy permits both organizations to provide family planning counselling and services as a part of their programs and to prescribe oral contraceptives as well as rhythm as a method of birth regulation.

Fifteen (39.5%) of the 43 family planning clinics operated by MFC and PALF are located in parish facilities, and in many instances the priests and nuns associated with these parishes are encouraging and promoting the use of these medical services. Also, regional and local health directors of the Ministry of Health (MOH) are beginning to encourage MFC and PALF to establish clinics in their facilities. Thirteen clinics (30.2%) are now housed in facilities of the MOH, or of a local government, and personnel of these establishments not only refer patients for services but also participate in motivational work.

Unless the programs of MFC and PALF, and that of APPF (the IPPF affiliate in Peru), are continued, the momentum now building for a government sponsored national program will be jeopardized. The three organizations are almost totally dependent upon external support for their existence, and if this is withdrawn they will be forced to terminate or drastically reduce their operations.

Recommendations

1. It is recommended that the broad educational goals of the MFC and PALF programs be understood and accepted for their value by the donor organizations and that judgements about the continued financing of the programs not be based exclusively on the number of oral contraceptors that the organizations are able to attract. The principal goal of both programs is to promote responsible parenthood primarily through educational efforts. Their medical assistance component is viewed as an important adjunct to their programs, but not as a goal in itself. It is in this context that the Catholic hierarchy has agreed that oral contraceptives can be made available to women for a two year period following a delivery. The use of orals is justified on the basis that child spacing is a practice which safeguards the health of mothers and helps reduce maternal mortality, thereby protecting the wellbeing of families and promoting responsible parenthood.

   Furthermore, it is the educational goal which not only makes it possible for MFC and PALF to offer contraceptive services but also to attract and retain leadership and staff.

2. It is recommended that the donor organizations take immediate action to aid MFC and PALF improve the quality of their programs.

   First of all, both groups need assurance that external assistance will be continued for a reasonable period of time, perhaps as much as five years. Secondly, MFC and PALF need to be encouraged to think in terms of what they can and must do to encourage government to finance family planning on a nationwide basis. This, perhaps, should be their priority focus if they are sincere about their long range goal of extending Christian concepts of responsible parenthood throughout Peru. Obviously, a national effort will necessitate public financing, but neither MFC or PALF is thinking beyond the annual targets which must be set and achieved in order to attract financial support from external sources.

Thirdly, the donor groups should provide the technical assistance which will enable the organizations to operate with maximum efficiency and effectiveness within their financial limitations. Both groups need additonal help with planning, programming, budgeting and evaluating the educational and medical assistance components of their programs.

Modifications #3 for Projects Peru-04 and Peru-05, covering the period October 1973, through September 1974, are illustrative of the requirement for the recommended technical assistance. The targets for the medical assistance component of the programs are set in terms of the number of new clinics to be opened and the number of new acceptors to be obtained, without any indication of how many will be acceptors of the oral or of the rhythm method. There is no mention of targets to reduce dropouts, which in the case of the PALF program seems quite high, nor is there mention of targets to increase the number of new acceptors per clinic session. Additionally, the educational targets are vague. Those set by MFC are measurable insofar as numbers of courses to be offered are concerned, but the target of PALF is stated as follows: "Increase the number of education courses, using new materials, to correspond to the expected increase in clinic patients."

The budgets included in the Project Modifications are also illustrative of the need for technical assistance. In some instances the number of personnel in a particular category are shown, as well as the time they are to devote to the program (full-time or part-time), in others there is no such indication; e.g., the number of outreach workers, called "clinic messengers" by PALF and "local promotors" by MFC, is seldom shown and the number of days worked per week by these employers is not given at all.

The budget for PALF operations in the Callao Health Centers and in other facilities in Callao and Huarochiri, is presented on an area basis. The number of clinics and clinic sessions are not given by area, thus there is no basis for assessing the adequacy of the staffing pattern by area or clinic. For Huacho, Ica and Huarmey the information is more specific and, therefore, it is possible to pinpoint possible weaknesses in the staffing plan. For example, the family educator in Huarmey is shown as a part-time employee (66% of time), yet she is expected to do community work as well as to assist with the conduct of six clinic sessions per week.

Another puzzling aspect of the Project Modifications is that increases in salaries are budgeted for several members of the PALF organization but none are budgeted for MFC.

3. The annual budget requests which are submitted to donor organizations would be more meaningful if they included information about plans for the use of the fees which MCF and PALF receive for medical consultations. The collection of a small fee from all who are able to pay is a practice established by the official health organization of Peru and is not one initiated by MFC or PALF.

4. Recommendations for improving the educational component of the MFC and PALF programs are as follows:

   a. Provision of technical help for an in-depth assessment of present activities and the development of a long range action plan, including staffing.

   b. Support for organized formal training of the outreach workers who make community contacts to interpret the program and its benefits and who make follow-up visits to patients who fail to keep their appointments.

   c. Provision of limited amounts of audio-visual equipment, such as movie and slide projectors, to enable staff to make use of available films and slides.

   d. Provision of sufficient copies of those movies and slides that have been found useful in Peru and other areas of Latin America so that more than one showing an evening will be possible.

   e. Provision of prototype educational aids, such as flip charts, pamphlets and posters, to aid the staff to develop teaching aids and promotional materials.

   f. Provision of recent publications pertinent to the educational component of the program to stimulate professional growth and development of staff.

5. It is recommended that the following steps be taken to improve the medical assistance component of the program:

a. MFC is urgently in need of approximately 200 specula and an adequate number of suitable containers to keep the instruments sterile from the time they are removed from the autoclave at the headquarters office to the time that the clinic physician uses them in his examination of patients. In the present emergency the consultants believe that AID should authorize local purchase of these instruments.

b. Orders for the equipment and supplies which are to be purchased and supplied by the donor organizations should be filled and delivered as promptly as possible. The FPIA project officer told the consultants that the equipment and supplies, which were to be provided under the fiscal year 1973 grant, had not been received by MFC and PALF because of a ruling made in November 1972, that all orders be placed with GSA, and that FPIA had been unsuccessful in getting action from GSA on their requests for purchases. AID is urged to look into this matter and to expedite the purchase and delivery of the items, all of which are needed to improve the programs of MFC and PALF, and to enable the clinics to operate in a proper, safe and dignified fashion.

c. Both Peruvian organizations need technical assistance in defining minimum statistical requirements for use in setting realistic targets, assessing clinic load and performance, determining staffing requirements, and making modifications in patient regimens. The record systems seem adequate, but much of the essential data is never compiled. Both organizations depend on staff members who have other functions to also undertake statistical compilations. This is probably one of the principal reasons why the compilation and analysis of basic data appears to have such a low priority.

d. Everything possible should be done by the donor organizations to assure that MFC and PALF have available, at all times, the amounts and types of oral contraceptives that they request.

e. Many of the clinics which the consultants visited are housed in facilities which were designed and are, in fact, used for other purposes when the clinics are not in session. Space is limited and furnishings are inadequate for patient comfort and dignity and for efficient performance by staff.

However, many improvements could be made with a relatively small investment. It is recommended, therefore, that the donor organizations encourage MCF and PALF to study their clinic settings and to make improvisations and modifications which will result in an efficient, safe, dignified and effective clinic service.

6. A final recommendation is that the donor groups exert their influence to promote goodwill and cooperation between MFC and PALF and between these organizations and other groups that are involved in the promotion of responsible parenthood and family planning, particularly the APPF.

   It seems doubtful that a merger of MFC and PALF will ever occur, and certainly it is not likely to happen anytime in the immediate future. Furthermore, it is possible that a merger might prove to be more detrimental than beneficial. Both organizations have developed a different base of support, MFC being more closely related to the Archdiocese of Lima and PALF more closely related to dependencies of the Ministry of Health and to the Bishops of other dioceses in Peru. These latter seem to have a more liberal attitude toward the use of oral contraceptives beyond a two year post-partum period and as a part of the regimen for couples who adopt the rhythm method.

   There are several steps that the donor organizations could take to foster improved cooperation between MFC and PALF. These are:

   a. Encourage regular meetings between members of the executive staffs of the two organizations and of APPF. All have common problems and each have strengths which the other do not have. There is great need for frank disucssion about problems and the measures that have been or can be taken to resolve them and for the exchange of program materials and data.

   b. Help the organizations to develop common yardsticks to be used in measuring performance and in reporting progress and problems. These yardsticks should be applied to both the educational and the medical assistance components of their programs.

   c. Assure that the staffing patterns of the organizations are compatible with their workloads and that when salary increases are indicated they are granted to staff of both MFC and PALF in an equitable manner.

PROGRAM OF THE CHRISTIAN FAMILY MOVEMENT

This report was prepared by two consultants who visited Peru under the auspices of the American Public Health Association, (APHA), to evaluate the "administration and the delivery of services" of the responsible parenthood programs of the "Movimiento Cristiano Familiar" (MFC) and of "Asociacion de Trabajo Laico Familiar" (ATLF). The consultants, who arrived in Lima on September 11, and departed on September 21, 1973, were a public health physician and a public health educator, both of whom had experience in the organization, implementation and evaluation of responsible parenthood/family planning programs.

The consultants prefer to describe the results of their efforts as an assessment rather than as an evaluation. Time did not permit an in-depth study of the programs of MFC and PALF, though an effort was made to obtain as much information as possible about their activities and to observe as many aspects of their operations as feasible. Unfortunately, some of the baseline data that the consultants needed was not obtained, either because it did not exist or could not be compiled in the time available. It is recognized, therefore, that the assessment of the two programs is superficial and incomplete in some respects. In spite of this, it is hoped that the report which follows will be useful not only to donor organizations but more importantly to those responsible for directing the MFC program.

The consultants are grateful for the frank and uninhibited participation of MFC staff members in the assessment process and wish to take this opportunity to express their appreciation for the "overtime" hours which were spent in compiling program information and in making it possible for them to observe field conditions and program operations. Grateful acknowledgement is offered also for the many personal courtesies which were extended.

A. Background Information

In April, 1967, the Christian Family Movement (Movimiento Familiar Cristiano - MFC) of Peru initiated an action program which is called "Program of Promotion for Marriage and Family" (Programa de Promocion Coyugal y Familiar - PPCF). The program operates with the approval of the Catholic Archdiocese of Lima and its activities are directed and carried out by lay persons affiliated with the MFC.

1. Program Goal

   The goal of the program is the promotion of responsible parenthood, especially among the residents of the areas of Lima populated by individuals in the lower socio-economic strata of society. These areas are called young towns (Pueblos Jovenes) although some of them have been populated for many years. According to information provided by MFC staff there are approximately 250 "Pueblos Jovenes" in the Archdiocese of Lima with a population of more than one million, but as of September 1973, the program was operative in only 20 of them. In two of the 20, El Savador and Comas, there were six clinics while in each of the other 18 there was one clinic.

The program of MFC consists of two major elements: education and medical assistance, both of which are described later in the report.

2. Organization and Administration

   Table 1 (MFC) illustrates the organizational plan of the Responsible Parenthood Program of the Christian Family Movement.

   Consistent with the philosophy of the Christian Family Movement that husbands and wives should work as a team, the Directing Council (Consejo Superior) is composed of three couples: Mr. & Mrs. Federico Hurtado, (Presidents). Dr. & and Mrs. Rafael de la Puente, and Dr. and M[illegible] [illegible]ardo Subiria. Dr. Subiria functions als[illegible] [illegible]he Director of the program.

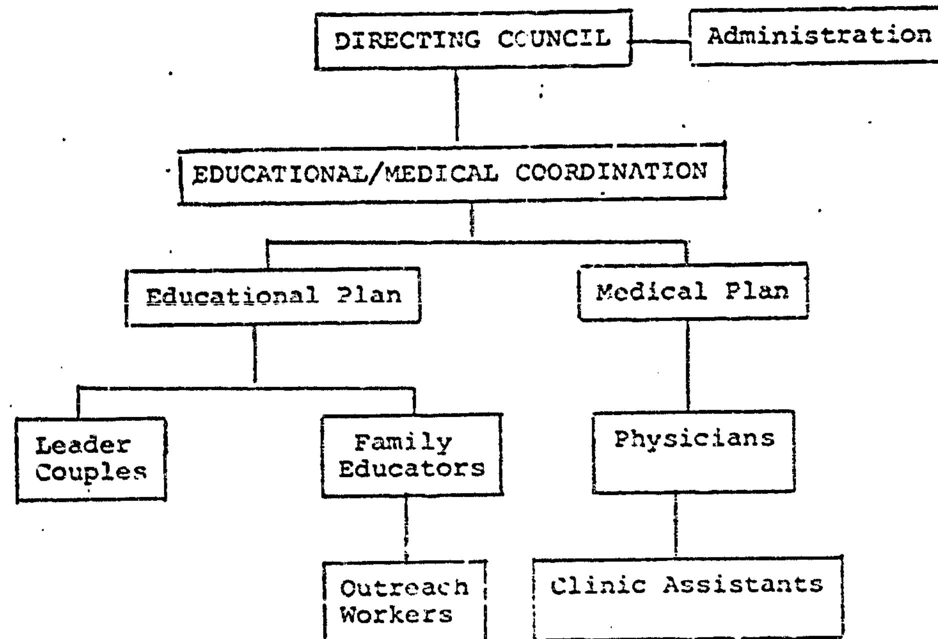
   Responsibility for the coordination of program activities is assumed by the Educational/Medical Coordination group. This is an inter-disciplinary team comprising a physician, a training specialist, a family educator and a priest. The team has two principal functions; to assure that both the educational plan and the medical plan are implemented in accordance with established criteria; and, to provide continuing education for program staff through courses and meetings.

3. Staffing

   The program staff, paid from project funds provided through Family Planning International Assistance (FPIA), totals 45 persons. Twelve staff members

Table 1 (MFC)

ORGANIZATIONAL CHART
RESPONSIBLE PARENTHOOD PROGRAM
CHRISTIAN FAMILY MOVEMENT (MFC)



are employed full-time and 33 part-time. Those working full-time are as follows: one administrator, five family educators, two clinic assistants, one secretary, one file clerk-messenger, one porter, and a guard for the MFC clinic in Pamplona which is housed in a facility belonging to the Population and Development Studies Center (CEPD).

Seventeen of the 33 part-time employees are outreach workers (promotoras) who are paid for two days work per week. The remaining 16 part-time employees are paid for 66 percent of the work week and comprise the following: the program director, seven physicians, seven clinic assistants, and an office helper.

In addition to the above, there are 14 leader couples (parejas lideres) who participate in the educational work of MFC and who receive a stipend for each of the educational sessions they conduct.

4. Relationship With Other Organizations

The headquarters of the program is located in Lima in space adjacent to that occupied by the Center for Training and Promotion of the Family (Centro de Capacitacion y Promocion Familiar) for which Dr. and Mrs. Subiria are the Co-Directors. The Center is a self sustaining operation, financed by fees charged for the design and conduct of training programs for government and private organizations and by the sale of publications issued by the Center.

The MFC program has realized many benefits as a result of its relationship with and proximity to the Center. A member of the Center staff serves without pay as the theological advisor to the program and also as its prinicpal education and training consultant. Other personnel of the Center are also available for consultation as needed. When possible and appropriate, members of the program staff are invited to participate, without charge, in courses which the Center conducts for other groups. Publications of the Center are also made available for the use of MCF program personnel.

Contacts between MFC, PALF, and the Peruvian Association for Family Protection (APPF) have been minimal, although program personnel have from time to time participated in courses given by APPF. And, on occasion, representatives from the three organizations have served as speakers or panel members at meetings of various groups. Several of the MFC staff members, including the Director, stated that they would welcome a closer relationship because they believe the programs of the three groups would be strengthened

by a regular exchange of ideas and information. A major recommendation of this report is that sustained efforts be made to improve communications and to foster joint planning.

5. Funding of the Program

From the initiation of the program, in April 1967, through June 1972, the principal source of support for the program was the AID Mission in Peru. Beginning on July 1, 1972 the responsibility for planning and supervising external support was transferred to the Family Planning International Assistance (FPIA), a division of Planned Parenthood-World Population. The transfer occurred shortly before the beginning of the 1973 fiscal year with the result that FPIA did not have time to make an in-depth study of the program before entering into budget negotiations. Apparently, the ceiling under which FPIA had to operate did not permit funding at the level that MFC had expected and needed. One result was a reduction in staff, notably among family educators and outreach workers.

When the FPIA project officer went to Peru to help with the preparation of a budget submission for fiscal year 1974, the funding ceiling situation still posed a problem. As a result the submission did not include provision for all of the additional staff believed necessary, nor for the increase in salaries needed to compensate for the rise in the cost of living which had occurred in Peru.

Apart from the space and furniture made available to the program by the facilities in which the MFC clinics are housed, the only other source of local support is the S/10.00 fee collected from clinic patients able to make this donation. Moreover, during fiscal year 1973 the funds derived from this source which had been earmarked for out-reach workers had to be diverted for the purchase oral contraceptives. Because the order placed with FPIA in September, 1972 did not arrive until a year later. This further handicaps the fiscal year 1974 situation since MFC has a reduced reserve upon which it can draw to meet emergencies and to cover items which do not appear in the budget submission prepared in collaboration with the FPIA project officer.

6. Problems Inhibiting Program Efficiency and Effectiveness

Problems specifically related to the educational and medical components of the MFC program are

discussed in subsequent sections of this report. There are, however, at least five others not mentioned in these sections which have had or continue to have a detrimental effect on program operations. They are:

a. When the former director of the MFC program was discharged, and subsequently founded the PALF program, several key members of the MFC staff left to join the new organization. This, no doubt, resulted in some disruption in MFC service until replacements could be recruited and readjustments made in the staffing pattern.

b. MFC was notified on July 20, 1973 that FPIA had approved a six months extension of its grant and that it would not be at the level planned for fiscal year 1974, ($109,762.48) but would be at the fiscal year 1973 level ($69,057.00). Thus, for the six month period July 1973 through December, 1973, the grant would be $34,528.00. (Editorial note: On October 1, 1973, the full amount requested for FY 74 was approved.)

   This action, of course, had a demoralizing effect on the entire organization. Many staff members surmised that external support would terminate in December, 1973 and, as a result, some began to explore other employment opportunities. It is to the credit of all, that MFC program operations have not been curtailed more drastically and that in spite of the uncertainties and frustrations to which the personnel has been and continues to be subjected, they continue to work with enthusiasm.

c. The transfer of responsibility for external support to an organization which does not have a local representatives makes it necessary for MFC to depend upon correspondence and the telephone for consultation with the donor organization. The FPIA project officer handles projects in countries other than Peru and, therefore, does not have frequent or extended contact with the MFC program.

d. The Director of the MFC program serves on a part time basis. Hence, he cannot attend to many of the tasks that this position calls for.

e. In addition to fulfilling the normal duties of an administrative officer, the incumbent

assigned to that position also serves as the statistical officer for the program and as an active participant in the "leader couple" aspect of the educational program.

B. The Educational Component of the Program

1. Objectives of the Educational Plan

In essence the educational component of the program is aimed at helping couples to learn how to enhance their married life and to properly discharge their parental responsibilities. The objectives of the educational effort are:

a. to promote understanding of the meaning and the practice of responsible parenthood;

b. to bring about a closer relationship between husband and wife and to prepare them to seek solutions for the problems which are affecting their conjugal and family life;

c. to develop an appreciation for the respect and dignity of the human person;

d. to get families to attend to their educational responsibilities;

e. to eliminate erroneous concepts which mitigate against the dignity of the individual, conjugal and family life, the education of children, the regulation of fertility, and health and hygiene;

f. to promote participation in the medical assistance component of the program as well as in the educational component;

g. to develop among the members of the family a critical, introspective and creative attitude toward each other and toward the community at large; and

h. to achieve, among the members of the family, an awareness of the role that each should assume within the home and in the community.

2. Educational Plan and Activities

The educational component of the program comprises community contacts with individuals and groups to stimulate interest and participation in the

responsible parenthood courses and to promote the use of the medical services provided through the program; individual patient and family counseling during patient visits to the clinics and during visits made by program staff to homes and the places of employment of patients and potential patients; the conduct of courses on responsible parenthood; meetings with groups having special interests, e.g., groups wishing instruction on the rhythn method, those desiring additional discussions on subjects dealt with during the reponsible parenthood course or information on related themes such as nutrition, disease prevention, drug abuse, and alcoholism; and training programs for leader couples.

At the beginning of fiscal year 1974, the staff involved in the above activities consisted of five family educators who are employed full time; seven physicians who work part time (66 %) 17 outreach workers who work two days per week; eight clinic assistants, two of whom work full-time and six part time, (66%); and 14 leader couples who are on call to conduct responsible parenthood courses as new groups are organized.

a. Promotional Activities

Promotional work is accomplished through personal contacts with community leaders and groups. These may be made by the parish priest, other church workers or by members of the program staff. The purpose is to inform the community about the program and to urge participation in it.

Basic Talks (Charlas Basicas) are one of the means used to stimulate interest. These Talks are are essentially a short course on some aspect of responsible parenthood and usually consist of three sessions held at weekly intervals.

A total of 135 "Charlas Basicas", attended by 2,240 couples, were conducted between July 1968 and July 1973.

Time Period	No. of Groups	No. of Couples
July 1968 - June 1969	6	97
July 1969 - June 1970	14	186
July 1970 - June 1971	34	562
July 1971 - June 1972	38	605
July 1972 - June 1973	43	790
Total	135	2240

The family educators and outreach workers are the members of program staff who assume major responsibility for the promotional aspects of the educational plan. Being indigenous to the area, it is usually the outreach worker who can more easily identify and contact community leaders and groups. The family educator follows-up by making a personal visit to individual leaders or by participating in meetings of community groups to discuss the educational and medical services offered by the program and to promote use of these services. This type of activity is identified by MFC as being motivational talks (Charlas de Motivacion). Numbers of groups and individuals involved are as follows:

Time Period	No. of Groups	No. of Persons
July 1970 - June 1971	31	425
July 1971 - June 1972	36	509
July 1972 - June 1973	54	918
Total	121	1,852

b) Patient Counseling

The responsibility for patient counseling is shared by the entire clinic team, including physicians, family educators, clinic assistants and outreach workers. All patients coming to the clinic for the first time are received by the outreach worker who quite often is already acquainted with the individual and, therefore, is in a position to make the person feel at ease. The new patient is then seen by the family educator who inquires about the type of attention the patient is seeking, provides information about the services offered by the program and the requirements for participation in it, and is the one who prepares the individual for the medical history and examination. Following this interview the patient is seen by the clinic assistant who fills out part of the medical record form and collects the fee of S/10.00 for the medical consultation.

The patient is then examined by the physician and receives instructions and conseling relative to the treatment of OB/GYN pathology or to the

contraceptive method which the patient has requested. If an oral contraceptive is prescribed, the patient is given a one month supply and an appointment is made to return in one week for observation of her reaction to the medication.

Before leaving the clinic the patient is seen again by the family educator who determines if the patient understands how to carry out the instructions given by the physician, either for correction of a pathological condition or the use of the prescribed contraceptive method; knows when to return to the clinic for her next appointment; understands that everyone who is accepted for medical attention is expected to participate with their spouse in a responsible parenthood course; and, if the patient has requested oral contraceptives she realizes that her husband must sign a consent form.

The procedure for a patient already active in the program is shorter. The outreach worker welcomes her and collects her identification card. This is given to the clinic assistant, who pulls the medical record and, depending upon the needs expressed by the individual and the purposes for which the appointment was made, either refers the patient to the physician or family educator or simply provides another one month supply of the oral contraceptive and collects the S/10.00 fee.

When space and circumstances permit, the family educator may also hold group meetings during clinic hours either to interpret the proper use of oral contraceptive, discuss the rhythm method, or to stimulate interest in the responsible parenthood course.

Home visiting is carried out by the family educator and the outreach worker. When a patient fails to keep a clinic appointment the outreach worker makes a home visit to determine the reason and to give another appointment date if she can convince the individual to remain in the program. The family educator attempts to contact the husbands of the women who have been

unsuccessful in obtaining the required signed consent and also the husbands of those who are unable to get their spouses to agree to attend a responsible parenthood course.

c) Selection, Characteristics and Training of Leader Couples.

The conduct of the responsible parenthood courses is largely the responsibility of leader couples, although family educators and physicians assist with some of the sessions.

Among the prerequisites for selection as a leader couple are the following: the couple must participate in a responsible parenthood course; show evidence of the ability to communicate with each other and with other people; indicate the desire and willingness to share their experiences as husband and wife and as parents with others; be willing to work with the groups to which they are assigned; be available at the times they are needed; complete the training program provided for leader couples; and agree to meet with other leader couples once each month for continuing education purposes.

Completed training programs for leader couples is as follows:

Locale of Training	No. of Groups	No. of Couples
Parish of Nstra. Sra. de la Paz, Comas	1	5
Parish of San Martin de Porras	1	4
Parish of Collique	1	4
Parish of Santiago Apostol, Comas (Arriba)	1	2
Parish of Nino Jesus, Ciudad de Dios	1	5
Parish of Nstra, Sra de Guadalupe	3	15
Headquarters of MFC	2	8
Total	10	43

When the program was initiated in 1968, all of the leader couples were affiliated with MFC. The trend now is to select couples who come from the areas where the program offers service. As of September, 1973, there were 14 leader couples who were active in the program; ten were residents of one of the Pueblos Jovenes and four were from other areas of Lima.

The leader couples are not committed to serve for any definite period of time, therefore, the make up of the group changes from time to time. New recruits are added regularly and some couples who find they can no longer devote the time required retire from the program either temporarily or permanently.

The following information was provided about those who were on the active list at the time of the consultant visit:

Number of leader couples:	14
Educational level:	Beyond High School (22.85%) High School Graduate (77.15%)
Occupation:	White collar workers (65%) Laborers (35%)
Residence:	Lima (28.5%) Pueblos Jovenes (71.5%)
Average age:	Between 35 and 50 years

d) Responsible Parenthood Course

When it is deemed that a sufficient number of candidates are available (10 to 12 couples), the date is set for the initiation of a new course. The locale for the course, selected on the basis of its convenience to those who are to participate, may be a parish hall or office, a community center, a school or a health center. The course sessions are held once a week for approximately three months and are usually scheduled for evening hours or Sundays. The first session with a new group is conducted by the family educator who serves the area. Its purpose is to provide orientation

about the subjects to be covered in subsequent sessions and the discussion methods that are to be used.

The next 11 sessions are conducted by a leader couple, with occasional help from program staff. For example, at the session prior to the one during which medical questions and problems are to be discussed, the family educator may help the leader couple prepare the members of the group for a meaningful dialogue with the program physician.

At the last session, the family educator and other program staff are often present since it is during this session that the participants give their evaluation of the course and are awarded a certificate.

The course is built around three major themes: conjugal love, sex as a part of marriage, and the education of children. A program guide, developed by MFC to aid the leader couples and the staff who participate in the courses, sets forth the objective of each session; suggests the topics to be discussed, the questions to be raised and the concepts to be conveyed; contains reminders about the methodology which has been found to be most effective in promoting discussion on the particular topic; offers suggestions about methods to use to help the group summarize the most important outcomes of their discussion on the topic or theme as a whole; includes reminders about what should be done to prepare the group for the next session; and finally, suggests the types of observations that the leader couple or staff member are to make and record so that future sessions and courses can be improved.

The impact that the responsible parenthood courses have had on family life is, of course, difficult to assess, but the program staff, leader couples, church leaders and local priests are convinced that this aspect of the program is the most important part of the entire MFC operation.

A majority of the individuals who have taken the course indicate that it has helped improve their relationships with their spouse and children. Some attribute this

to the fact that it has taught them how to communicate; to bring their feelings about one another out into the open; to learn to listen and to understand the meaning of what their spouse or child is trying to say; to not be embarrassed by demonstrating affection for each other. Other comments made by participants are "that the home environment is more congenial," "the husband isn't drinking as much as before," "he brings his pay home for the support of his family," "the wife (or husband" is more loving;" "the wife is less inclined to scream at her husband and children when she is upset;" and "the husband (or wife) has learned how the health and wellbeing of a family is threatened by unregulated fertility, untreated gynecological pathology and the lack of proper attention during pregnancy and childbirth."

The above is a summary of the information elicited from participants during the last session of the courses and in subsequent contacts during home visits or at the clinic and from leader couples.

The staff appreciates that the behavior and attitude changes reported by participants and the leader couples may or may not have occurred, but at least, the effort is being made to identify the strengths and weaknesses of the course.

An early effort to evaluate the courses was a study,[1/] conducted in 1972, which was a sample of 441 individuals, all of whom had taken part in one of the courses offered between December 1970, and December 1971. It was found that the respondents believed that the course was extended over too long a period; that the interval between sessions (one week) was too great; and that more visual aids would be helpful. Members of the MFC staff reported that a decision to shorten the course will be made in the near future although there is still uncertainty about how all of the essential subject matter can be handled in six sessions, the number under consideration.

1/ Reprints of the study, originally published in the "Revista Teologica de Lima", 1972, have been published by the Centro de Capacitacion y Promocion Familiar, Lima, and are available on request.

There were 33 responsible parenthood courses in progress and others were in process of formation in September, 1973. The data obtained on number of groups and participating couples is included in Table 2 (MFC). The figures are most impressive for two reasons; the number of couples who have participated in the courses, and the upward trend in number of groups organized each year.

Table 2 (MFC)
PARTICIPATION IN COURSES ON RESPONSIBLE PARENTHOOD
July 1968 - June 1973

		No. of Groups	No. of Couples
I	Courses for Couples Inscribed in the Program		
	July 1968 - June 1969	24	216
	July 1969 - June 1970	49	401
	July 1970 - June 1971	107	1,041
	July 1971 - June 1972	121	1,223
	July 1972 - June 1973	152	1,368
	TOTAL	453	4,249[1/]
II	Courses for Members of Parent-Teacher Groups		
	July 1971 - June 1972	11	375
	July 1972 - June 1973	18	410
	TOTAL	29	785
	GRAND TOTAL	482	5,034

The extent of the evening and Sunday workload of staff and leader couples is demonstrated by the 1972-73 statistics showing that 272 groups were formed comprising 1778 couples. The family educators meeting twice with each group, averaged 108 sessions per educator; the staff physicians meeting once with the groups average 34+ sessions per physician; and the leader couples meeting 11 times with the groups averaged 199+ sessions per leader couple.

[1/] 70% reported to have completed the course .

3. Problems Affecting Implementation of the Educational Plan

The problems can be summarized as follows:

a) The number of family educators and outreach workers presently employed is insufficient for the workload expected of these employees.

b) Organized formal training is not provided for the outreach workers who perform important educational functions.

c) The lack of adequate transportation discourages community work, especially during evening hours when safety is a factor.

d) Audio-visual equipment, teaching aids and educational materials are inadequate or in short supply.

e) The lack of sec[illegible]arial/clerical assistance makes it necessary for the family educators to spend an inordinate amount of time on tasks which could be handled by clerical personnel.

f) Those involved in the educational plan do not have ready access to recent publications dealing with such subjects, as responsible parenthood, family planning, group process, program design, evaluation methods, training methods, communication techniques, interviewing skills, organization of patient flow in the clinic, analysis and presentation of statistical data, and the organization of community resources.

C. The Medical Assistance Component of the Program

1. Services Provided

The MFC operates 24 clinics in the Pueblos Jovenes of Lima. Weekly clinic sessions total 30 and the services provided include the following:

a) Contraception for two years post-partum.
b) Cancer detection without contraception.
c) Diagnosis and treatment of gynecological pathology.
d) Infertility treatment.

2. Clinic Schedule and Staffing

The clinics are usually operative in the afternoons for a period of approximately three hours. Information concerning the clinics including the facilities in which they are housed, the dates that services were initiated and the schedule of sessions is contained in Table 3 (MFC).

Each clinic session is supposed to be staffed by a physician, a family educator, a clinic assistant, and an outreach worker, however, the MFC did not have sufficient funds to make this staffing pattern possible in all instances. With six clinic sessions scheduled each afternoon, Monday through Friday, the five family educators employed by MFC could cover only 25 of the 30 sessions. As a result, the clinics in Tupac Amaru, Ermitano, Caja de Agua, Progreso, and Tablada de Lurin were operating without the services of a family educator.

Another deficiency was the number of outreach workers employed by MFC. These individuals, part time employees (2 days per week), are responsible, along with other duties, for follow-up on missed visits. There were 17 outreach workers in September, 1973 instead of the 24 needed to provide a minimum of one for each clinic area. Since six of the clinics have two sessions per week, even 24 outreach workers may not be sufficient unless those serving these clinics are employed full time or at least for four days per week.

3. <u>Acceptors and Dropouts</u>

The numbers of acceptors of oral contraceptives and drop-outs, as well as the active caseload at the beginning of the reporting periods, are shown in Table 4 (MFC).

There were no acceptors of the rhythm method until fiscal year 1970. Since that time the program has assisted 1,373 couples adopt this method as follows: 63 in 1970; 580 in 1971; 647 in 1972; and 83 in 1973. It is interesting to note that while 647 couples selected this method in 1972 there were only 83 adopters in 1973. The reasons for this descrease were not obtained nor was information provided about the number of clinic visits required of those adopting the rhythm method.

Table 3 (MFC

CLINIC INFORMATION

NAME OF CLINIC 1/	FACILITY HOUSING CLINIC	CLINIC SCHEDULE	NUMBER SESSIONS PER WEEK	DATE CLINIC OPENED	NUMBER OF MONTHS IN OPERATION
AGUSTINO	Parish Building	2:30/5:30 pm Wednesday and Thursday	2	Apr 1967	75
COMAS 11	Parish Building	2:30/5:30 pm Tuesday	1	June 1967	73
COMAS 13	Medical Post of MOH 2/	2:30/5:30 pm Wednesday	1	June 1967	73
TUPAC AMARU	Rented Space	2:30/5:30 pm Monday	1	Jan 1973	6
ZARUMILLA	Medical Post of MOH	2:30/5:30 pm Monday 8:30/12:00 am Friday	2	Sept 1967	70
DOS DE MAYO	Parish Building	2:30/5:30 pm Tuesday and Wednesday	2	June 1967	73
TABLADA DE LURIN	Parish Building	2:30/5:30 pm Friday	1	May 1973	2
ERMITAÑO	Rented Space	2:30/5:30 pm Thursday	1	Nov 1967	68
CAQUETA	Municipal Health Center	2:30/5:30 pm Friday	1	Apr 1968	63
CAJA DE AGUA	School	2:30/5:30 pm Tuesday	1	May 1968	62
COMAS 12	Parish Building	2:30/5:30 pm Friday	1	Oct 1968	57
SAN RICARDO	Parish Building	2:30/5:30 pm Thursday	1	Nov 1969	44
CIUDAD DE DIOS	Parish Building	2:30/5:30 pm Tuesday	1	Dec 1969	43
SURQUILLO.	Parish Building	2:30/5:30 pm Tuesday	1	Dec 1969	43
FATIMA	Community Center	2:30/5:30 pm Thursday	1	Nov 1972	8
12 NOVIEMBRE/SAN LUIS	Community Medical Post	2:30/5:30 pm Wednesday	1	June 1973	1
COLLIQUE	Parish Building	2:30/5:30 pm Monday	1	Feb 1971	28
VILLA Ma. DEL TRIUNFO	Parish Building	2:30/5:30 pm Monday	1	July 1971	24
VILLA EL SALVADOR	Parish Building	2:30/5:30 pm Thursday and Friday	2	Oct 1972	9
EL SALVADOR (1)	Parish Building	2:30/5:30 pm Monday and Wednesday	2	Jan 1973	6
AÑO NUEVO	Parish Building	2:30/5:30 pm Tuesday	1	Nov 1972	8
PAMPLONA	C.E.P.D. 3/	2:30/5:30 pm Monday and Friday	2	July 1971	24
PROGRESO	Commercial Building	2:30/5:30 pm Thursday	1	Dec 1971	19
EL SALVADOR (1)	Private Home	2:30/5:30 pm Wednesday	1	July 1973	-

1/ All clinics of MFC are located in

2/ Ministry of Health

3/ Population and Development Studies Center

Table 4 (MFC)

ACTIVE CASELOAD, NEW ORAL CONTRACEPTORS
AND DROPOUTS - APRIL 1967 TO JUNE 1973

Time Period	Active Caseload beginning of period	No. New acceptors during period	Total Served during period	Dropouts during period No.	Dropouts during period %
April 1967 - May 1968	0	1,231	1,231	312	25.3
June 1968 - June 1969	919	1,510	2,429	623	25.6
July 1969 - June 1970	1,806	1,287	3,093	618	20.0
July 1970 - June 1971	2,475	1,287	3,762	803	21.3
July 1971 - June 1972	2,959	1,544	4,503	658	14.6
July 1972 - June 1973	3,845	2,079	5,924	757	12.8
July 1973	5,167	-	-	-	-
TOTAL	-	8,938	-	3,771 1/	

1/ See Table 5 for information about Reasons for Dropouts

The statistics on contraceptors and individuals seeking other types of service do not show numbers of visits per patient, by type of service (gynecological consultation, cancer detection, contraception consultation, etc.) or by type of patient (new, continuing). This type of data is needed to assess clinic performance, to make judgements about staffing requirements and the numbers of sessions needed at each clinic, and to determine whether change in the regimen used for the various types of patients is indicated.

Table 5 (MFC) provides information concerning dropouts among the acceptors of oral contraceptives. It should be noted that among the various reasons given for dropouts, there is no category covering those who were dropped by the program after they had completed two years on the oral contraceptive. It may be that some of them were transferred to the rhythm method and are counted among the 1,373 couples reported as using this method. The statistics on dropouts, however, does not show this since there is a category for "Change to Other Method" and only 46 individuals are listed as having done so; three between April, 1967 and May, 1968 and the remainder between July 1972 and June, 1973. Another possibility is that the patients who were no longer eligible after two years of oral contraceptives are counted in either the "Lost" or "Inconvenience" categories.

As shown in Table 5 (MFC) during the period April 1968, through June 1973, 66.1 percent of all dropouts were women lost to the program (no return to clinics, moved away). During the year 1972-1973, however, the percentage of women categorized as lost was significantly reduced, while the percentage of those dropping out because of side effects increased to 13.1 percent, the highest in the life of the program. This increase is attributed by the medical staff to the change in oral contraceptives made necessary when the expected shipment from the United States was not received. The physicians reported an increase in break-through bleedings from changes in the brand of oral contraceptives and they expressed considerable irritation because of their inability to retain their patients on the type of oral contraceptive which had proven to be successful from the point of view of side effects and acceptance.

The significant increase in the number of dropouts classified as leaving the program because of

Table 5 (MFC)

REASONS FOR DROPOUTS BY NUMBER AND PERCENTAGE
April 1967-June 1973

Time Period	REASON																Total Dropout
	Lost		Side Effects		Inconvenience		Husband Opposed		Pregnancy		Fear		Change to Other Method		Desired Pregnancy		
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.
April 1967-May 1968	141	45.2	30	9.6	34	10.9	30	9.6	59	18.9	12	3.8	3	1.0	3	1.0	312
June 1968-June 1969	483	77.6	13	2.1	60	9.6	6	0.95	49	7.8	8	1.3	-	-	4	0.65	623
July 1969-June 1970	501	81.1	16	2.6	52	8.4	4	0.65	40	6.5	4	0.65	-	-	1	0.1	618
July 1970-June 1971	590	73.5	41	5.1	81	10.1	31	3.9	38	4.7	10	1.2	-	-	12	1.5	803
July 1971-June 1972	527	80.1	22	3.4	56	8.5	7	1.1	37	5.6	5	0.7	-	-	4	0.6	658
July 1972-June 1973	270	35.6	99	13.1	210	27.7	21	2.8	66	8.7	36	4.8	43	5.7	12	1.6	757
Total	2512	66.6	221	5.9	493	13.1	99	2.6	289	7.7	75	2.0	46	1.2	36	1.0	3771

"Inconvenience" (56 in 1971-1972 and 210 in 1972-1973), is another change which should be studied. It may be that many women gave this as a reason when in reality they became disenchanted because of side effects. In any event, the reason for this increase should be pinpointed.

The services provided to contraceptors at the clinics include instructions on useage, a physical examination including pelvic, PAP smear and diagnosis of vaginal infection. The medical staff stated that vaginal infections are present in approximately 90 percent of the clients and that Trichomoniasis is by far the most prevalent infection. Prescriptions are given by the physician and the patients are told how to use the medication, which they are responsible for purchasing at a pharmacy.

Reporting of activities and requests for funding usually make mention only of the contraception component of the clinical service, though other services are provided. In addition to the patients who visit the clinics for contraception, a significant number of women receive diagnosis and treatment of gynecological conditions. During the period July 1972 through June 1973, the program served a total of 6,462 patients who were seeking gynecological care. An additional 2,530 women received PAP smears, and a few patients received infertility diagnosis and treatment.

During the year July 1972 through June 1973, 60 percent of the contraceptors were between 20 and 29 years of age, and 9 percent were women under 19 years of age. The average age was 27 years, the average number of pregnancies was 4.6 and the average number of living children was 3.7.

5. Problems Affecting Implementation of the Medical Assistance Plan

   a) The MFC waited for a year, September 1972 to September 1973, before the oral contraceptives ordered from FPIA were received. Because of this long delay it was necessary to borrow and to make purchases of locally available oral contraceptives. Some were borrowed from a Peruvian University, others from PALF and APPF. During the emergency, five different brands had to be used and this, no doubt, accounted for the significant increase in side effects previously mentioned. The contraceptives supplied by the University, the APPF and PALF

were Norlestrin, Ovral and Ovulen; the ones purchased locally were Neogyxon and Miniplanor. Three thousand cycles of orals were purchased in Peru in February and again in May 1973, and an additional 1,000 cycles were purchased in August 1973. The purchases were financed with money collected through the S/10.00 fee charged for medical consultation.

b) Because of the problem of obtaining oral contraceptives, the MFC was forced to curtail clinic operations. For a period of four months no new patients were admitted to the program, and this, no doubt, accounts for the fact that the 1972-1973 target of 3,000 new acceptors was not met for had the acceptance rate of the other eight months been maintained there would have been over 3200 new acceptors.

c) Essential medical instruments and supplies which the program staff expected to receive from FPIA during fiscal year 1973 had not been delivered in September 1973, nor were provisions made to permit the local purchase of the commodities. Of particular concern are the specula which are desperately needed. The number on hand that are in useable condition, is totally inadequate for the six clinic sessions which are held each day. Since this is the case, once the sterile supply has been exhausted the clinic physician must either turn patients away or clean the specula as best he can. Sometimes the specula are merely rinsed in water or, as occurs in some clinics dipped in a solution which is supposed to sterilize them. This, of course, is not only poor medical practice deplored by the physicians, but is also likely to result in the spread of infection among patients and community distrust in the program.

d) Most of the MFC clinics are housed in facilities which are neither designed nor equipped for the delivery of a health services. As a result, improvisation is the order of the day. Also, most of the facilities are used by other groups on the days and during the hours that the clinics are not in operation. This makes it necessary for the staff to carry instruments, equipment, records and supplies back and forth between headquarters and the clinics. These items must be picked up at headquarters, transported to the

clinic, unloaded, unpacked and then put in place. Once the clinic session is over the same procedure is carried out in reverse order.

e) The MFC has been unable to provide its clinic personnel with books and other publications that would enhance professional growth. As one of the clinic physicians put it, he feels as though he is merely a pill pusher, without opportunity to broaden his knowledge about contraceptive technology or the delivery of family planning services.

D. Observations and Suggestions

It is understood that the budget crisis which existed at the time of the consultant visit has been resolved and that a new grant covering the period October 1, 1973 through September 1974 has been made by FPIA. This action provides a period of grace during which MFC will be able to demonstrate its ability to strengthen both the educational and medical assistance components of its program, especially the latter.

Throughout the report an effort has been made to pinpoint problems which seem to be inhibiting the efficiency and effectiveness of the MFC program and to suggest approaches which might be used in resolving them. The effort has been made also to commend the strengths of the program and the dedication and enthusiasm displayed by the staff.

This section of the report is to present a synthesis of impressions about the MCF program as a whole and to offer suggestions for its further development.

1. It has been recommended to the donor organizations that external support for the MFC program be continued for an indefinite period, perhaps five years or more. The services provided by MFC are needed and valuable. However, the MFC can and should assume a leadership role in stimulating the understanding and action which would result in the development of a national responsible parenthood goal and of the programs needed to achieve this goal. It is suggested, therefore, that MFC, working in concert and harmony with the other organizations which are actively involved in responsible parenthood and family planning activities, broaden its horizons and become a potent force in helping to convince government that the regulation of fertility is a health measure which can help to promote responsible parenthood. Obviously, a private organization cannot expect to obtain sufficient

funds from private sources to finance a national effort. A long range goal, therefore, should be to get government to improve its maternal and child health services and to provide family planning services as an integral part of its health care system.

2. Another important goal for MFC would be to convince public authorities and others who influence public opinion and government action that the achievement of responsible parenthood and citizenship requires an intensive and carefully designed educational program which encompasses both sexes and all age groups, not solely those in or approaching the reproductive period of life. Therefore, MFC should continue working with groups such as the Ministry of Education (MOE) and the National Assistance Council (JAN) to help develop personnel and curricula for family life and sex education programs for school children and members of youth and adult groups. In the interest of a coordinated and fruitful effort, the MFC is urged to consult with PALF and APPF about their plans and activities since these organizations have also been invited to participate in programs of MOE and JAN.

3. The immediate priority of MFC should be to upgrade it own operations, not only to assure the survival of its program but equally important to be in a position to demonstrate to government authorities and other leaders that a responsible parenthood program can be operated efficiently, effectively, economically and successfully. To accomplish this there are several approaches which need to be considered and some urgent problems which need to be resolved.

    a) Although the record system of MFC is probably quite adequate, much greater emphasis needs to be given to compiling and analyzing the data it produces. Unless this is done it will be difficult if not impossible to measure accomplishments, to set realistic targets, and to make sound judgements about staffing requirements and revisions that may be needed in the educational and medical assistance components of the program. MFC should give a high priority to the development of a viable and useful evaluation system. Additional staff and/or technical assistance may be required and should be obtained without delay.

b) The medical component of the MFC program needs emergency attention. It is estimated that approximately 200 specula are required for existing clinics along with proper containers to assure that they are not contaminated prior to the time that the clinic physicians put them to use. It has been recommended to the donor agencies that in the event that immediate delivery cannot be assured by FPIA, local purchase be authorized and additional funds provided for this purpose.

c) It is recognized that a majority of the facilities in which the MFC clinics are housed were designed and are used for other purposes. Nevertheless, with a few changes and at a small cost the patients could be provided with some of the comfort and privacy that they deserve and the staff could have an environment conducive to increased efficiency and effectiveness. It is suggested, therefore, that MFC encourage the staff of each clinic to study the possiblities for improving patient flow, to identify requirements for furniture and other items. A committee consisting of a representative of each category of clinic staff might be useful in coordinating this activity. Also, visits to the clinics of other organizations might prove to be helpful.

d) Some staff members appear to believe that the talks and courses sponsored by MFC constitute the entire educational program, not realizing that promotional activities and patient counseling during clinic and home visits are also important elements of the educational process. It is suggested, therefore, that MFC take steps to assure an integrated educational effort and to prepare all of its staff members for the educational functions they need to perform to enable MFC to achieve its goals and objectives.

Technical assistance from within Peru or from an external source might be helpful in guiding the design of an integrated educational effort. The plan should focus on clearly defined long and short range objectives, the evaluation measures to be used, a description of the educational responsibilities of the various members of staff, the type of training that is indicated for each discipline, and the kinds of teaching aids and audio visual materials that are needed for the various elements of the educational program.

e) With regard to the upgrading of the program, MFC needs to give high priority to improving the procedures and methods employed in planning, programming, budgeting, assessing and reporting on performance. MFC would benefit from expert advice and to be of real help the individual providing the assistance should spend several weeks working side by side with staff of MFC.

PROGRAM OF THE FAMILY LAY APOSTOLATE

This report was prepared by two consultants who visited Peru under the auspices of the American Public Health Association, (APHA), to evaluate the "administration and the delivery of services" of the responsible parenthood programs of the "Movimiento Cristiano Familiar" (MFC) and of "Asociacion de Trabajo Laico Familiar" (ATLF). The consultants, who arrived in Lima on September 11, and departed on September 21, 1973, were a public health physician and a public health educator both of whom had experience in the organization, implementation and evaluation of responsible parenthood/family planning programs.

The consultants prefer to describe the results of their efforts as an assessment rather than as an evaluation. Time did not permit and in-depth study of the programs of MFC and PALF although an effort was made to obtain as much information as possible about their activities and to observe as many aspects of their operations as feasible. Unfortunately some of the baseline data that the consultants needed was not obtained, either because it did not exist or could not be compiled in the time available. It is recognized, therefore, that the assessment of the two programs is superficial and incomplete in some respects. In spite of this, it is hoped that the report which follows will be useful not only to donor organizations, but more importantly to those responsible for directing the PALF program.

The consultants are grateful for the frank and uninhibited participation of PALF staff members in the assessment process and wish to take this opportunity to express their appreciation for the "overtime" hours which were spent in compiling program information and in making it possible for them to observe field conditions and program operations in the Lima and Callao areas. Grateful acknowledgement is offered also for the many personal courtesies which were extended.

A. Background Information

The "Programa Apostolado Laico Familiar" (PALF) began operations in May 1970, under the leadership of Mr. Pedro Pazos Gamio who previous to that time had served as the Executive Director of the responsible parenthood program of the Christian Family Movement (MFC).

The official organization which sponsors the PALF program is the "Asociacion de Trabajo Laico Familiar" (ATLF). The creation of ATLF was authorized by

the Peruvian hierarchy of the Catholic Church with the understanding that PALF (The action program of ATLF) would extend Christian concepts of responsible parenthood and child spacing within dioceses of the Church outside of Lima. It was stipulated also that before a local program can be initiated, PALF must obtain written approval from the Bishop of the diocese and the support of the priests who serve the parishes within whose boundaries the program is to operate.

1. Program Goals

The goals of the program are:

a. to study the realities and actual situations of Peruvian families to establish an atmosphere of responsible parenthood;

b. to carry out adequate education programs for achieving a closer family relationship between father and mother and parents and children for achieving an open family life;

c. to consolidate or legalize marital unions for the purpose of teaching the responsibilities and obligations that one parent has to the other;

d. to teach the necessity for families to live as a community, respecting each other, and working to achieve communal goals;

e. to offer gynecological medical services to all requesting mothers; and

f. to provide services for regulating births according to the norms of Christian morality.

By September, 1973 the PALF program was operative in the dioceses of Callao, Huacho, and Ica, the prelature of Yauyos and, in addition, in one facility in Miraflores which is a part of the greater Lima area. There were 19 clinics in operation with a total of 33 sessions per week. Fourteen of the clinics were in health facilities of the Ministry of Health (MOH), municipalities or private health organizations, four were in space provided by a local parish; and one in a building which had been donated to PALF.

2. Organization and Administration

The PALF was reorganized during the summer of 1973 when the executive director was removed

from office and the direction of the program was assumed by an Executive Committee (Comite Directivo) comprising a Chairman, Secretary, Theological Advisor, and two other members (vocales), one of whom represents the Administrative Council of ATLF, and the other the Bishops of the participating dioceses.

A majority of those who form the Executive Committee are not only officers of ATLF but also serve the PALF program in various capacities. Dr. Heli Cancino, President of ATLF, is the representative of the organization on the Executive Committee of PALF and also serves as Medical Director (central) of the program; Father Enrique Bartra, Vice President and theological advisor to ATLF is also Theological Advisor to PALF; Dr. Guillermo Tagliabue, Secretary of ATLF, is Chairman of the Executive Committee of PALF and the Medical Director (field) for the program; Mr. Carlos Flores, Treasurer of ATLF is also Secretary of the Executive Committee and the National Coordinator of the PALF program.

There are three major departments in the PALF organization: Education, Social Service and Medical. A director for the Education Department had not been named as of September 1973 and the Chief of Courses was serving as Acting Director on an interim basis.

The organizational structure of ATLF and PALF is shown in Table 1 (PALF).

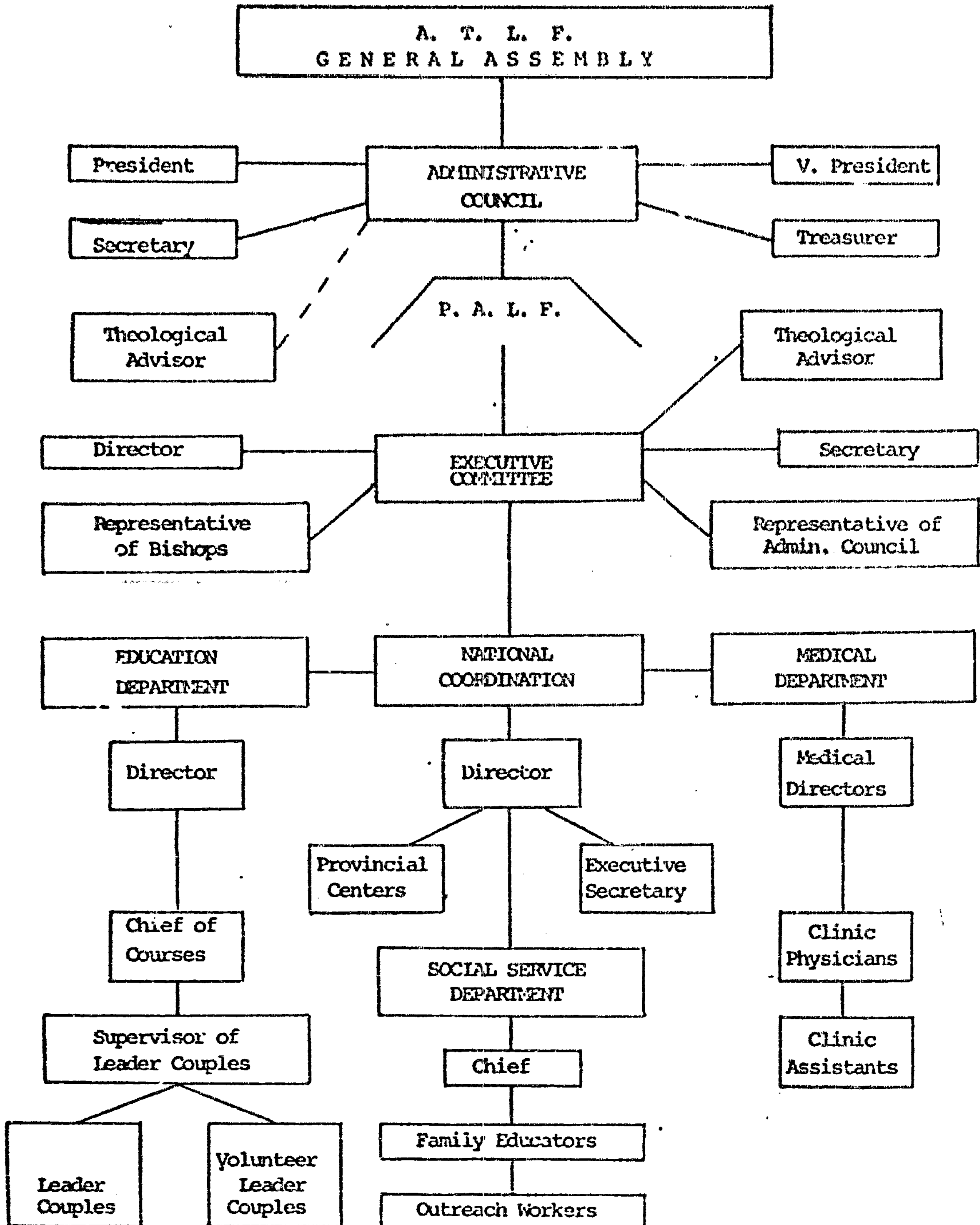
The headquarters of PALF is located in an office building in downtown Lima. The executive staff, office personnel, and the family educators and clinic assistants who serve the Callao and Huarochiri areas work out of this office. Information was not obtained about the type or location of the headquarter facilities used by PALF personnel in Ica, Huacho and Huarmey.

3. Staffing

In September, 1973 the PALF had 51 employees, 18 employed full time and 33 part time. In addition, seven leader couples (parejas lideres) were participating in the program.

The 51 employees were as follows: a national coordinator; two medical directors; a theological advisor; three provincial coordinators; six clinic physicians; a pediatrician; a executive secretary; a chief of courses; a supervisor

Table 1



of leader couples; nine family educators; nine clinic assistants (auxiliares de clinicas); one messenger and 15 outreach workers (mensajeras).

4. Relationship with other organizations

Contacts between PALF, MFC and the Peruvian Association for Family Protection (APPF) have been minimal, although from time to time their staff members have participated in training programs sponsored by APPF and other institutions. Also, representatives of the three organizations meet on other occasions when they are speakers or panel members on programs of other groups.

Several members of the PALF organization reported that they would welcome a closer relationship with MFC and APPF, believing that the programs of all could be strengthened by a regular exchange of ideas and information. A major recommendation of this report urges that sustained efforts be made to improve communcations and to foster joint planning.

5. Funding

From May, 1970 through June 30, 1972, the PALF program was supported by the Pathfinder Fund, the AID Mission in Peru through a grant to the Population and Development Studies Center (CEPD), inkind contributions from catholic parishes and local communities and funds generated from fees charged by PALF for medical consultations.

Beginning July 1, 1972, the Family Planning International Assistance (FPIA), a division of Planned Parenthood - World Population, assumed responsibility for external support and the grants formerly provided by the Pathfinder Fund and the AID Mission were terminated. The decision for FPIA to fund the PALF operations occurred shortly before the beginning of the 1973 fiscal year and as a result FPIA had only a short period in which to become familiar with the program before entering into budget negotiations.

Apart from FPIA funds and the inkind contributions from the parishes and agencies which provide space for program operations, the only source of revenue available to PALF is the cash realized from the S/15.00 fee for medical consultations.

Much of the small reserve accumulated from the consultation fees was depeleted during the period 1972-1973 when it became necessary for PALF to buy oral contraceptives on the local market. An order was sent to FPIA in September, 1972 but the contraceptives were not received until August, 1973. Thus, PALF was required to make local purchases to keep its clinic program in operation.

6. Problems Inhibiting Program Efficiency and Effectiveness

PALF was notified on July 19, 1973 that FPIA could only approve a six month extension of its grant and that the amount approved was not at the level planned for fiscal year 1974 which was $114,204.68 but would be at the level approved for fiscal year 1973 which was $98,810.00. This action, of course, had a demoralizing effect on the entire organization. Fiscal year 1973 had been a year of growth for PALF. New areas had been incorporated into the program at various times during the year and the 1973 grant had been based on the months that each new area would be served. The executive staff was of the opinion, therefore, that the $49,405.00 which was the amount granted for the first six months of fiscal year 1974 (July 1, 1973 through December, 1973) would only cover operating costs through November, 1973. Many of the other staff members were aware of this fact and morale hit a new low. (Editorial note: As of October, 1973, PALF was funded at the levels requested for FY 74)

Another traumatic experience for the PALF staff occurred during the summer months of 1973 when the Director was discharged and the new organization was established. It was obvious that all of the changes that had been made did not meet with the approval of some staff members and that there was some confusion about the role and functions of the individuals comprising the executive committee.

Other problems which specifically relate to the educational and medical components of the PALF program are discussed in subsequent sections of this report.

B. The Educational Component of the Program

1. Objectives of the Educational Plan

In general terms, the aim of the educational component of the program is to help couples to

learn how to enhance their marraige and to discharge properly their parental responsibilities. The stated objectives are:

a) to investigate and understand the realities of the family unit;

b) to consolidate and legalize family unions (marriage);

c) to help create responsible parenthood; and

d) to project the family unit responsibilities to include the community.

2. Educational Plan and Activities

The educational activities of PALF include four elements: promotional work including individual contacts and the conduct of meetings and short courses in the communities in which the program is operative and in others where future action is contemplated; patient counseling during clinic and home visits; responsible parenthood courses; and extension courses for couples who request additional discussions on the themes included in the responsible parenthood course or on related topics which were not included. A fifth element, yet to be initiated, is a School for Leaders. This is to be a training program which will last two to three months and is primarily for the purpose of preparing leader couples for the PALF program.

a) Promotional activities

The promotional work in the areas served by the program is carried out through personal contacts with community leaders and other residents. These may be made by the parish priest, other church workers or by members of the program staff, particularly the family educators and outreach workers. The purpose is to inform residents of the community about the program and to urge their attendance at the basic talks (Charlas Basicas) which are offered to all who wish to learn more about the program or who are thinking about becoming participants.

According to the PALF plan, efforts are to be directed toward the recruitment of a large group (approximately 70 couples) for the "charlas" program which consists of one to three sessions. The large group is then to be divided into smaller groups of 10 to 15 couples for a course on responsible parenthood. In addition, the plan envisions an extension course of three sessions for couples who request additional discussions.

The couples who are participating in the "charlas" program or in a responsible parenthood course, or those who have already completed one of them, are eligible to seek the medical attention offered by PALF for the regulation of pregnancies. In actual practice, many women are admitted to the medical assistance component of the program before attending a "charla" or a responsible parenthood course. Some come to the clinic for the diagnosis and treatment of gynecological pathology; others for a PAP smear; and still others to request oral contraceptives or instructions on the rhythm method. These clinic contacts, of course, offer the staff many opportunities for promoting attendance at the "charlas" and responsible parenthood courses. A great amount of the promotional work and much of the recruitment for the education courses occurs during clinic hours.

b) Patient Counseling

Patient counseling, while not identified as education by many of the staff members of PALF, may likely be one of the more important parts of the educational effort. Almost everyone connected with clinic operations plays a role in patient counseling. During an individual's first visit to a clinic she is interviewed by the family educator who tells her about the educational and medical assistance services offered by the program and the requirements that the paitent must fulfill to be eligible for services. After the new patient has been seen by the physician, the family educator again talks with her to make certain that she understands what she

recommendations of the physician; that she appreciates the importance of keeping her next appointment; and, if she has requested oral contraceptives, to remind her that she must obtain the written consent of her husband within a month. The family educator also emphasizes the requirement for participation in a responsible parenthood course and tries to stimulate enrollment by describing how the patient and her husband would benefit from this type of learning experience.

During subsequent visits the family educator often meets with the patient to counsel on family problems and to promote and encourage behavior which may help alleviate them.

The physician, of course, makes a diagnosis and gives instructions about the rhythm method and the proper use of medications, including oral contraceptives. He tries to alleviate the physical or psychological reactions toward any side effects which a patient who is on orals may be manifesting. Another educational role of the physician is in the area of sex education. Many of the patients know very little about human reproduction and others have a great deal of misinformation about human sexuality, pre-natal, obstetrical and post-natal practices, and methods for regulation of fertility.

The clinic assistant also participates in the educational process, especially with the patients receiving oral contraceptives. Once these patients no longer require or request consultation with the physician or family educator, the clinic assistant becomes their principal contact in the clinic. She is the staff member who provides the patient with her monthly cycle of pills, collects the S/15.00 fee, and reminds the individual when she is to return for the next cycle, a check-up examination or her annual PAP smear. Without doubt, the clinic assistant is asked and tries to answer many questions about the safety, side effects and the effectiveness of contraceptive methods. It is likely that the clinic assistant and the outreach work are the first

members of the clinic team to learn about rumors that are being spread about the quality of the services provided by the program, and the ineffectiveness or damage caused by contraceptives.

The outreach worker, usually a resident of the area in which the clinic is located, not only helps with promotional activities but also follow-ups on missed appointments. These are, of course, important educational functions.

c) Responsible Parenthood Course

Leader couples and some of the PALF staff members, notably the physicians and family educators, are responsible for the conduct of responsible parenthood courses. These courses are intended to prepare husbands and wives, both those in legalized and in common law relationships, to communicate in a meaningful way and to learn how to share the responsibilities of rearing a family, giving their children the love, guidance and education that will enable them to grow up to be well adjusted individuals and ones who are capable of becoming good citizens and responsible parents.

A responsible parenthood course consists of six sessions, one per week, during which the following topics are discussed: communications between husband and wife; psychology of the man and the woman; responsible parenthood; sex education; human reproduction; and the needs of children. All who complete the course are awarded a certificate of achievement.

The PALF staff reported seven active leader couples as of September, 1973; three from Lima and one each from Callao, Ica, Haucho and Haurmey. It is apparent that PALF has encountered problems in recruiting leader couples and that either the husband or wife of most of the seven leader couples who are active in the program are employed by PALF in a staff role; e.g., as Chief of Courses, Supervisor of Leader Couples, or as a clinic physician.

A course manual in the form of a 74 page booklet has been published by PALF. It was

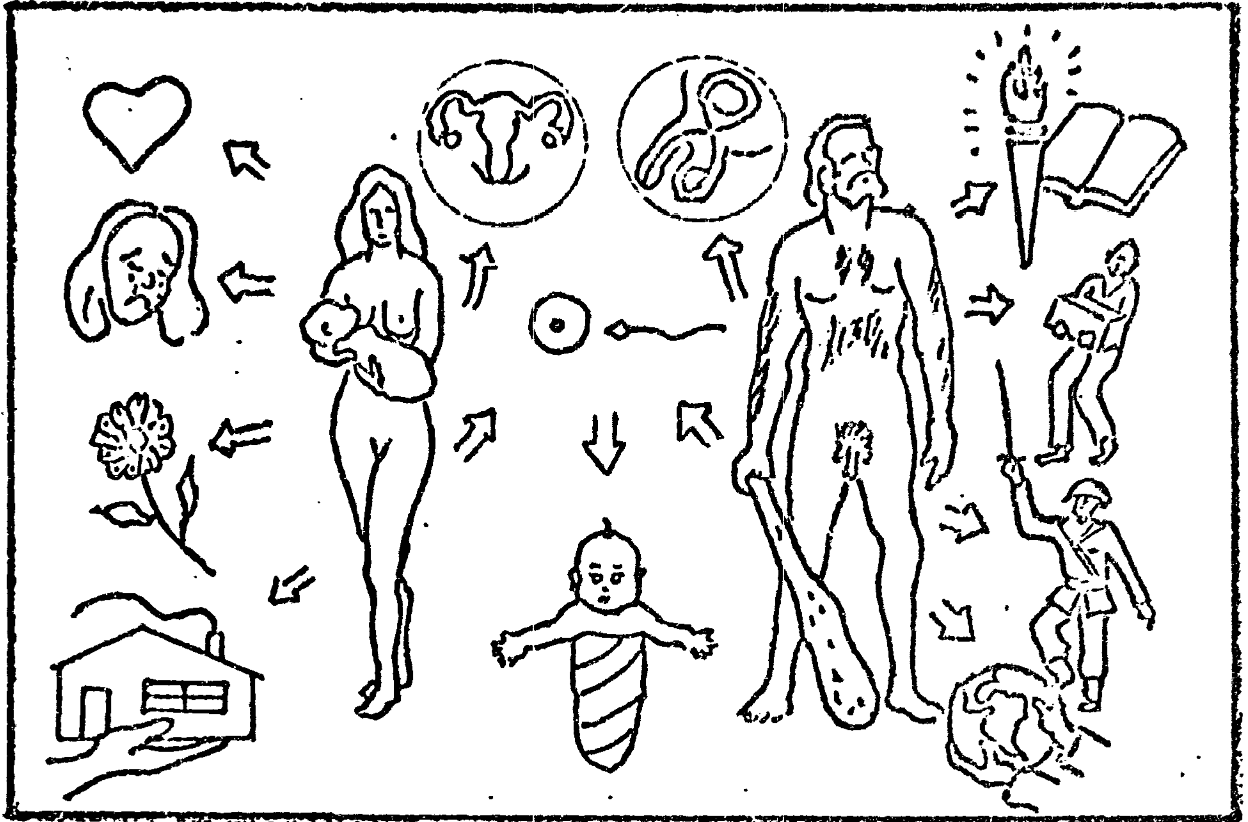
designed by the Chief of Courses, and has been distributed to the leader couples and staff members who conduct or participate in the responsible parenthood courses. The manual contains a short description of the PALF program as well as the objective for each of the six sessions, the methodology to be followed, and the principle points to be made.

Also available for the use of the teaching group is a single set of 20 posters which are called "iconodramas", a term invented by a member of the PALF staff. Each of the posters is intended to help convey a series of messages, therefore, on each there are numerous illustrations. Examples are shown on the following page. Reproductions of the iconodramas are included in the manual along with a description of the message that each individual illustration is supposed to reinforce.

It was reported that the leader couples and staff have encountered difficulties in handling the poster materials and, therefore, seldom use them. It is obvious that the booklet and the posters are far too complicated for most audiences, including highly sophisticated groups. One suggestion under consideration by the Chief of Courses is to give a copy of the manual to all who complete a responsible parenthood course. This would be a waste of resources. Without a doubt the PALF needs teaching aids, but they should be useful to the leader couples and staff members in stimulating discussion or in illustrating the points they are trying to make. The visual aids should also be of a type that are easily handled by those who are to use them and, most important of all, the drawings and vocabulary must be easily understood by the audience.

The only statistics obtained about PALF sponsored responsible parenthood courses and the number of individuals participating in them are shown in Table 2 (PALF). The information covers activities in the Callao area only but it is assumed that other courses were held in Haucho Ica and Haurmey during the same reporting period, December 1972-June 1973.

Man and Woman. Physical and Psychological Differences



Sex Education. How to Talk to a Child

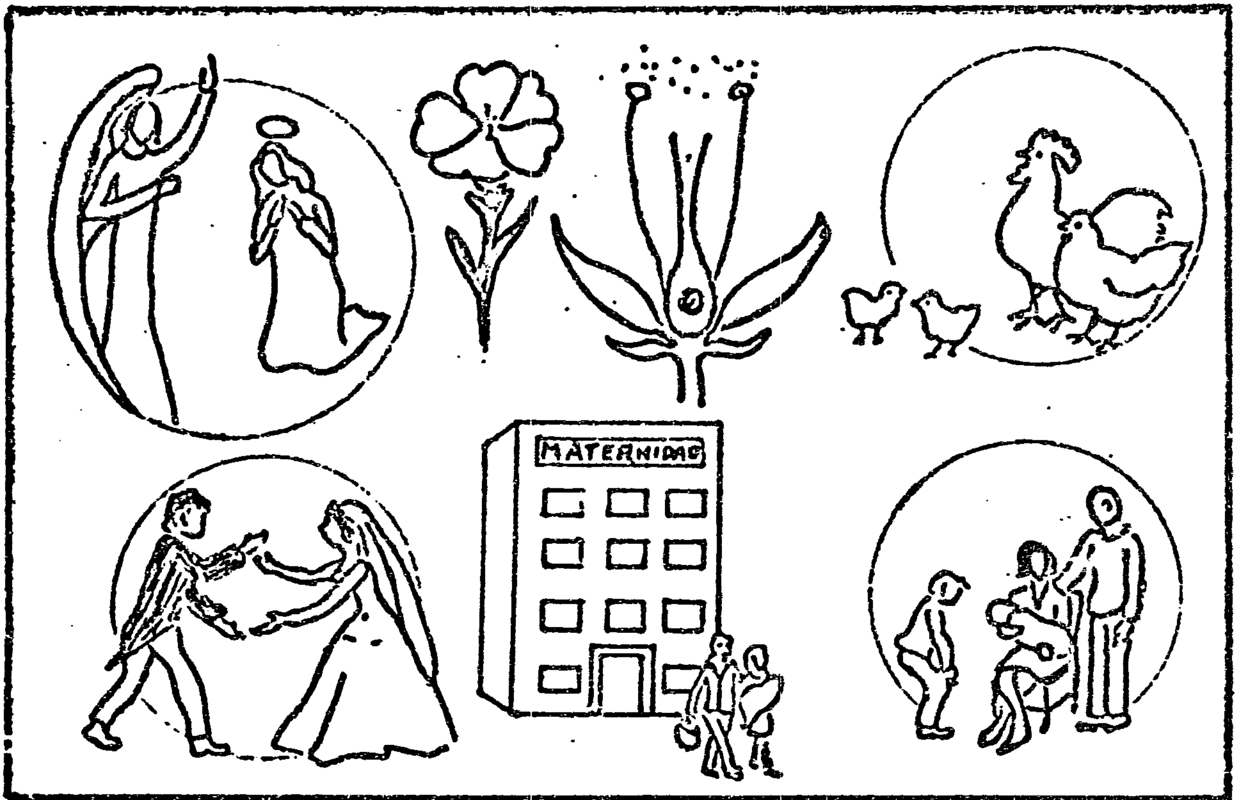


Table 2 (PALF)
Responsible Parenthood Courses
Callao Area
December 1972 - June 1973

Center	Group	No. of Persons Enrolled	No. of Persons Completing	No. of Couples Enrolled
La Perla	XVII	8	6	2
"	XVIII	9	5	4
"	XIX	30	22	8
"	XX	67	67	-
"	XXI	54	54	-
"	XXII	10	9	1
Reynoso	XI	13	10	3
"	XII	31	24	7
"	XIII	10	9	1
"	XIV	13	10	3
"	XV	8	8	-
Ricardo Palma	XIV	17	17	-
"	XV	23	19	1
"	XVI	13	13	-
"	XVII	60	56	4
"	XVIII	25	25	-
"	XIX	9	9	-
"	XX	34	34	-
Ventanilla	I	19	19	-
"	II	19	19	-
"	III	43	43	-
"	IV	13	13	-
Bonilla	I	12	9	3
"	II	19	15	4
"	III	17	11	6
Lazareto	I	8	8	-
"	II	8	8	-
"	III	18	18	-
"	IV	11	11	-
"	V	10	10	-
"	VI	10	10	-
"	VII	13	13	-
Constitucion	I	19	19	-
Ciudadela Chalaca	IV	23	23	-
"	V	11	11	-
Total	35	707	658	47

The information in the table indicates that most of those who attended the responsible parenthood courses were women since only 47 couples are shown as having participated. It is encouraging, however, that of the 707 individuals who enrolled in the courses 658, 93 percent, are reported to have completed the six sessions.

The PALF staff is fully cognizant of the fact that the effort made to involve men in the program have not been successful. There is much speculation as to why this is the case but as yet studies have not been made to identify the reasons.

d) School for Leaders

One item included in the PALF budget is earmarked for the establishment of a "School for Leaders". There appears to be a difference of opinion among the staff about the purpose of the School. Some seem to be of the opinion that this activity is to recruit and train leader couples to serve the program. Others believe that the School is to prepare individuals for leadership roles, not only for the PALF program, but also for other community action programs. Actually, PALF does not propose to set up a school in the sense of it being an institution with a permanent faculty and program, but rather plans to establish a training program which will be carried out on an ad hoc basis. After reviewing the proposed curriculum it appears that the primary purpose of the course is to recruit and train leader couples for PALF and that any other outcome would be welcomed but of secondary importance.

The training is to be built around 15 themes and field observations and practice sessions are to be integral parts of the training. An outline of the curriculum subject matter is contained in Table 3 (PALF).

3. Problem Affecting the Educational Component of the Program.

There are several problems which need attention, and among these the following are probably the most important:

Table 3 (PALF)

PROJECTED COURSE FOR FORMATION OF LEADERS

Introduction:	The leader; born or made?	(30 min.)
Theme 1:	Attitudes and customs of the residents of a Pueblo Jóven.	(2 hrs.)
Theme 2:	Genesis and structure of a Pueblo Jóven.	(1 hr.)
Theme 3:	Principles and Practice in Community Development.	(3 hrs.)
Practice:	Visits to Pueblos Jóvenes and Evaluation.	
Theme 4:	The Leader in History: from tribe to United Nations.	(3 hrs.)
Theme 5:	Types of leaders; political, military, religious, business, intellectual, community, group, family, students, criminal.	(3 hrs.)
Practice:	Interviews with community, business, labor, political, military and religious leaders. Evaluation.	
Theme 6:	Clear ideas about Man and Things.	(2 hrs.)
Practice:	Biographries of Leaders; shadows and light. Evaluation by participants.	
Theme 7:	Definition and Characteristics of leadership.	(3 hrs.)
Practice:	Communication Test-Sociodramas.	
Theme 8:	The things that a group accepts and rejects in a leader.	(3 hrs.)
Theme 9:	Seven steps in the formation of a leader.	(2 hrs.)
Practice:	Listen and learn; auditions of classical music.	
Theme 10:	Authoritarianism, Liberalism and Democracy.	(2 hrs.)
Practice:	Authority Laboratory.	
Theme 11:	Administration and Leadership.	(3 hrs.)
Practice:	Case Studies.	
Theme 12:	Demography and Family Planning.	(3 hrs.)
Theme 13:	Practical problems of community leadership.	(3 hrs.)
Practice:	Case Studies.	
Theme 14:	How to conduct a meeting.	(1 hr.)
Practice:	Observation of a labor or community meeting. Evaluation.	
Theme 15:	The art of public speaking.	(3 hrs.)
Practice:	Individual exercises.	
Evaluation:	Summary and Review	

a) There does not seem to be either a long range or short range educational plan to which all Departments are committed or have clearly assigned roles.

b) Educational targets (metas) are not defined in specific terms, therefore, the measurement of progress or lack thereof is difficult.

c) The educational skills of some staff members seem to be under-utilized, e.g., it did not appear that the family educators participate in decisions about the design and content of visual materials used in connection with "charlas, " and responsible parenthood courses.

d) The outreach workers who could play an important part in promoting acceptance of the program and in encouraging continuation in it have not been given training apart from that provided on an individual basis by their immediate supervisors, the family educators.

e) The lack of transportation, especially for the family educators, makes it difficult for them to carry out the community work they should be doing; such as identifying community groups and leaders, the patterns and channels of communications in the various areas, and the resources that might be obtained to enhance the clinic environment.

f) The audio-visual equipment and materials presently available for the use of staff and leader couples is inadequate.

g) The staff and leader couples who are involved in the educational component of the program do not have ready access to recent publications dealing with such subjects as responsible parenthood, family planning, group process, programming, evaluation, training methodology, communications techniques, interviewing, analysis and presentation of statistical data, and the organization of community resources in promoting responsible parenthood.

h) Many of those who are responsible for planning and programming the educational component have not been encouraged or given the opportunity for refresher training.

C. Medical Assistance Component of the Program

1. The PALF has 19 clinic locations with a total of 33 clinic sessions per week. Contained in Table 4 (PALF) is information about the 19 clinics in operation as of June 30, 1973.

   An individual attending the clinic for the first time has an interview with the family educator during which the reason for the visit, information about pregnancies, number of living and dead children, abortions, date of last delivery, and other pertinent data is ascertained. After this interview, the patient is seen by the physician.

2. Type of Medical Services Offered

   Four types of medical services are available: gynecological consultation; consultation because of sterility; cancer detection; and consultation for contraception, orals and rhythm.

   During the period May 1970 through June 1973 the number of women availing themselves of the services listed above were as follows: 7,792 for gynecological consultation; 321 for sterility consultation; 4,818 for cancer detection; and 5,820 for contraception consultation. Of those seeking contraceptive counseling 5,117 adopted oral contraceptives and 703 the rhythm method. It is not clear whether the 4,814 consultations for cancer detection represents the total number of PAP smears taken during the period or the number of women who came only for this purpose and who received no other type of consultation. The numbers of consultations by type and time period are shown in Table 5 (PALF).

   The patient who comes for a gynecological problem is examined by a physician who makes a diagnosis and recommends treatment. Most of the women who come for gynecological consultation do not return to the clinic again and generally no special history is taken. The visit is simply coded as gynecological consultation. The clients who come for other types of service, however, receive a complete physical examination and a more detailed examination of the gynecological tract.

Table 4 (PALF)

CLINIC INFORMATION

Name of Clinic	Province	Facility Housing Clinic	Clinic Schedule	Number Sessions Per Week	Date Clinic Opened	Months in Operation 1/
Ricardo Palma	Huarochiri	Health Center of MOH 2/	2:00/6:00 pm Tues	1	Sept 1970	33
Moyopampa	Huarochiri	Health Center of MOH	2:00/6:00 pm Thurs	1	Nov 1972	8
Reynoso	Callao	Parish Building	2:00/6:00 pm Mon and Wed	2	Sept 1970	33
San Jose	Callao	Hospital of MOH	2:00/6:00 pm Thurs	1	May 1973	2
La Perla	Callao	Parish Building	2:00/6:00 pm Mon and Fri	2	Sept 1970	33
Cuidadela Chalaca	Callao	PALF Building	2:00/6:00 pm Thurs	1	Aug 1971	23
Ventanilla	Callao	Health Center of MOH	2:00/6:00 pm Mon	1	Oct 1972	9
Bonilla	Callao	Health Center of MOH	2:00/6:00 pm Tues and Fri	2	Oct 1972	9
CS La Perla	Callao	Health Center of MOH	2:00/6:00 pm Mon	1	May 1973	2
Barton	Callao	Health Center of MOH	2:00/6:00 pm Thurs	1	Oct 1972	9
Puerto Nvevo	Callao	Health Center of MOH	2:00/6:00 pm Fri	1	Oct 1972	9
Constitucion	Callao	Health Center of MOH	2:00/6:00 pm Fri	1	Oct 1972	9
Huacho	Chancay	Parish Building	2:00/6:00 pm Mon through Fri	5	Mar 1971	28
Acomayo	Ica	Acomayo Clinic	2:00/6:00 pm Mon and Wed	2	Aug 1971	23
La Tinguina	Ica	Municipal Building	2·00/6:00 pm Tues and Fri	2	Apr 1972	15
San Joaquin	Ica	Maternity Hospital	2:00/6:00 pm Thurs and Sat	2	Oct 1972	9
Huarmey	Huarmey	Parish Building	2:00/6:00 pm Mon			
Culebras	Huarmey	Medical Post of MOH	through Sat 3/	6	Oct 1972	9
Hogar de la Madre	Lima	Private Clinic	2:00/6:00 pm Wed 4/	2	Aug 1971	23

1/ Through June 30, 1973
2/ Ministry of Health (MOH)
3/ Days of operation in Huarmey and Culebras clinics not known.
4/ Two physicians in attendance, therefore, counted as two clinic sessions.

Table 5 (PALF)

MEDICAL CONSULTATIONS BY TYPE AND TIME PERIOD

May 1970 - June 1972

Time Period	Gynecological Consultation	Infertility Consultation	Cancer Detection	Adopters of Contraception	
				Orals	Rhythm
May 1970 - June 1971	664	27	618	307	22
July 1971 - June 1972	2,516	98	1,200	1,700	100
July 1972 - June 1972	4,612	196	3,000	3,110	681
Total	7,792	321	4,818	5,117	703

Patients seeking infertility treatment are seen in the central office of the program which is located in Lima since the various tests which must be made require different physicians and facilities than are needed for the other consultation services offered by PALF.

For a client to receive oral contraception she must have a child under two years of age, otherwise the the rhythm method is the one in which she is instructed. Nevertheless, according to the physicians in the program, many of the patients who have children over two years of age are placed on a rotation of six months oral contraception and six months rhythm method. A regulation of menstruation is attempted through this methodology.

All patients on orals are examined every six months, contraceptives are provided monthly, and the PAP smear is done yearly. When the patient leaves the physicians office, she is seen by the clinic assistant who fills out the admission form. All new patients who are given oral contraceptives return after one week. Subsequently, their visits are on a monthly basis. Consent by the husband and enrollment in a responsible parenthood course are requirements for continuation in the program.

3. Acceptors and Dropouts

The numbers of acceptors of oral contraceptives and the estimated numbers of dropouts are shown in Table 6 (PALF). Also shown is the estimated active caseload at the beginning of the reporting periods.

Table 6 (PALF)

ACTIVE CASELOAD, NEW ACCEPTORS AND DROPOUTS - MAY 1970 TO JUNE 1973

Time Period	Active Caseload beginning of period	New acceptors	Total Served	Dropouts	
				No.	%
May 1970 - June 1971	0	307	307	76	25%
July 1971 - June 1972	231	1,700	1,931	492	25%
July 1972 - June 1973	1,439	3,110	4,549	1,228	27%
July 1973	3,321	-	-	-	-
Total		5,117	-	1,796	-

The slight increase in the dropout rate in fiscal year 1973 may be partially accounted for by the side effects which occurred when it became necessary for PALF to purchase orals in Peru whre it was impossible to obtain the same brand formerly provided to patients. Information about the reasons for the 25 to 27 percent dropout rate over the life of the program was not available.

4. Problems Affecting the Medical Assistance Service

PALF requested oral contraceptives in June of 1972 for fiscal year 1973. These were not received until August 21, 1973. The order placed with FPIA was for 30,000 cycles but only 27,227 cycles were delivered. Although the original request was for Ovulen, one half of the orals received were Ovulen 28 and the other half were Norlestrin 21. During the period July 1, 1972 to June 30, 1973, 24,953 cycles of orals were used by the PALF clinics. When delivery from FPIA was delayed, 18,800 cycles of Neogynon were purchased locally at a cost of S/454,629.45 which absorbed almost all of the funds collected from patients for medical services.

PALF has been hampered in its efforts to assess its clinic performance and medical assistance service partially because of a lack of modern equipment. The program has a good record system which produces the raw data needed for programming and evaluation. Much of the information collected, however, is not used because of outmoded equipment and the lack of staff trained in statistics. A calculator, which FPIA was to provide in fiscal year 1973, had not been delivered at the time of the consultants' visit.

D. Observations and Suggestions

It is understood that the budget crisis which existed at the time of the consultant visit has been resolved and that a new grant covering the period October 1, 1973 through September, 1974 has been made by FPIA. This action provides a period of grace during which PALF should be able to demonstrate its ability to strengthen both the educational and medical assistance components of its program, especially the former.

Throughout this report an effort has been made to pinpoint some of the problems that were observed and, in some instances, to suggest approaches which might

be useful in resolving them. The effort has also been made to commend the strengths of the program. The following is a synthesis of impressions about the PALF program as a whole and offers suggestions concerning its further development.

1. It has been recommended to the donor organizations that external support for the PALF program be continued for an indefinite period, perhaps five years or more. The services provided by PALF are needed and are valuable. However, PALF can and should assume a leadership role in stimulating understanding and action which will result in the development of a national responsible parenthood goal and of the programs needed to achieve this goal. It is suggested, therefore, that PALF, working in concert and harmony with other organizations which are actively involved in responsible parenthood and family planning activities, broaden its horizons and become a potent force in helping to convince the government that the regulation of fertility is a health measure which can help to promote responsible parenthood. Obviously, a private organization cannot expect to obtain sufficient funds from private sources to finance a national effort. A long range goal, therefore, should be to get government to improve its maternal and child health services and to provide family planning services as an integral part of its health care system.

2. Another important goal for PALF would be to convince public authorities, and others who influence public opinion and government action, that the achievement of responsible parenthood and citizenship requires an intensive and carefully designed educational program which encompasses both sexes and all age groups, not solely those in or approaching the reproductive period of life. Therefore, PALF should continue working with such groups as the Ministry of Education (MOE), and the National Assistance Council (JAN) to help develop personnel and curricula for family life and sex education programs for school children and members of youth and adult groups. In the interest of a coordinated and fruitful effort, the PALF is urged to consult with MFC, APPF and the Center for Training and Promotion of the Family (Centro de Capacitacion y Promocion Familiar) about their plans and activities since these organizations have also been invited to participate in programs of MOE and JAN.

3. The immediate priority of PALF should be to upgrade its own operations, not only to assure the survival of its program, but equally important to be in a position to demonstrate to government authorities and other leaders that a responsible parenthood program can be operated efficiently, effectively, economically and successfully. To accomplish this, there are several approaches which need to be considered and some urgent problems to be resolved.

   a) Although the record system of PALF is probably quite adequate, much greater emphasis needs to be given to compiling and analyzing the data it produces. Unless this is done it will be difficult, if not impossible, to assess progress, pinpoint problem areas, set realistic targets and make sound judgments about staffing requirements and revisions which need to be made in the educational and medical assistance components of the program. PALF should give high priority to the development of a viable and useful evaluation system. Additional staff and/or technical assistance if required should be obtained without delay.

   b) Priority should also be given to building staff morale. Now that the funding problem has been resolved, for at least the next twelve months, the executive staff should take immediate steps to foster confidence in the new organization and to promote teamwork at all levels. Staff meetings and regular field visits by supervisory personnel seem indicated. Members of staff need to be kept informed about plans that are under consideration and need to be encouraged to contribute to the planning process.

   c) The educational component of the PALF program is in an early stage of development and should be carefully studied before expenditures are committed for new activities.

      Some staff members appear to believe that the talks and courses which are given constitute the educational program of PALF, not realizing that promotional activities and patient counseling during clinic and home visits are also important elements of the educational process. Perhaps coordination between the Education and Social Service Departments exists, but it was not apparent. It is urged, therefore, that PALF take steps to assure an integrated educational effort and to prepare all of its staff members,

including physicians, clinic assistants and outreach workers, for the educational functions that they need to perform to enable PALF to achieve its goals and objectives.

Technical assistance from within Peru or from an external source would be helpful in guiding the design of an integrated educational plan. The plan should clearly define long and short range educational objectives, establish the evaluation measures to be used, describe the educational responsibilities of the various members of staff, identify the type of training that is indicated for each discipline, and delineate the kinds of teaching aids and audio-visual materials needed for the various elements of the educational program.

d) With regard to the medical assistance component of the program, environmental improvements are indicated in some of the clinics which could be achieved at a minimal cost. It is suggested, therefore, that PALF encourage its clinic staff to study ways of improving patient flow and to identify requirements for furniture and other items. A committee consisting of a representative of each category of clinic staff might be useful in coordinating the study and in formulating plans for increasing efficiency of staff and the privacy and comfort of patients.

e) With regard to the upgrading of the program, PALF needs to improve the procedures and methods it employs in planning, programming, budgeting, assessing and reporting on performance. PALF would benefit from expert advice and to be of real help the individual providing the assistance should spend several weeks working side by side with staff of PALF.